PRELIMINARY REPORT

GOVERNOR'S COMMISSION ON BLACK & MINORITY HEALTH

DECEMBER 1, 1986

INTERIM REPORT OF THE GOVERNOR'S COMMISSION ON BLACK AND MINORITY HEALTH

Larry Young, Chairman
Edward Brandt, Vice-Chairman

December, 1986

GOVERNOR'S COMMISSION ON BLACK AND MINORITY HEALTH

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Church Hospital

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EXECUTIVE ORDER

01.01.1986.05

Governor's Commission on Black and Minority Health

WHEREAS, The State of Maryland is concerned with enhancing the health of all of the State's citizens;

WHEREAS, Disparities exist in both the health status and utilization of health services between Black, Asian, Hispanic, Native American and other minority citizens and white citizens of Maryland;

WHEREAS, The infant mortality rate for minority citizens of Maryland is 90 percent higher than the infant mortality rate for white citizens;

WHEREAS, The overall age adjusted mortality rate for minority citizens is 40 percent higher than the rate of white citizens;

WHEREAS, Homicide and accidents are the leading causes of death for young black males between the ages of 15-34;

WHEREAS, While the cancer death rate for nonwhite males has been declining, there has been a significant overall increase in the cancer death rate for minority citizens;

WHEREAS, Minority citizens are twice as likely to be uninsured, four times as likely to be poor and twice as likely to be unemployed as white citizens;

WHEREAS, Minorities, particularly poor minority citizens, are less likely to have access to health care resources; and

WHEREAS, There are remaining disparities by race in a number of other key health indicators;

NOW, THEREFORE, I, HARRY HUGHES, GOVERNOR OF THE STATE OF MARYLAND, BY VIRTUE OF THE AUTHORITY VESTED IN ME BY THE CONSTITUTION AND LAWS OF MARYLAND, HEREBY PROCLAIM THE FOLLOWING ORDER EFFECTIVE IMMEDIATELY:

1. The Commission

There is a Governor's Commission on Black and Minority Health.

2. Membership and Procedures

A. The Commission shall consist of up to 30 members appointed by the Governor who are representatives of health providers, human resource, education and legal agencies or organizations as well as representatives of local communities and civic groups. Of the members appointed, the Commission shall include:

(1) One member of the House of Delegates nominated by the Speaker of the House;

(2) One member of the Senate nominated by the President of the Senate; and

(3) A representative of the Governor's Office.

B. The Governor shall select the Chairperson of the Council from among the members appointed to the Council.

C. The Governor may remove any member of the Council for any cause adversely affecting the member's ability or willingness to perform his or her duties.

D. In case of a vacancy, the Governor shall appoint a successor for the remainder of the life of the Commission.

E. A majority of the Council shall constitute a quorum for the transaction of any business. The Council may adopt such other procedures necessary to ensure the orderly transaction of business including the appointment of subcommittees or work groups utilizing the expertise of non Commission members.

F. The members of the Council may not receive any compensation for their services. The members may be reimbursed for their reasonable expenses incurred in the performance of duties, in accordance with the standard travel regulations, and as provided in the State budget.

G. The Department of Health and Mental Hygiene shall provide such staff support necessary for the completion of the Commission's duties and as provided in the State Budget.

3. Scope of the Commission

The Commission shall conduct a thorough examination of the programs and laws relating to the health status of Maryland's minority citizens and in doing so shall:

A. Hold hearings at which persons, organizations, and agencies with an interest in the health status of Maryland's black and other minority citizens may present their views;

B. Conduct meetings, discussions and examinations as necessary to gather information on the laws and services relating to minority health care in Maryland and other states;

C. Identify and examine the limitations and problems associated with existing laws, programs and services related to the health status of Maryland's minority citizens;

D. Examine the financing and access to health services for Maryland's black and minority citizens;

E. Examine the causes and recommend possible measures to address the increase in youth homicide particularly as it relates to young black males; and

F. Identify and review prevention strategies relating to the leading causes of death among minorities including heart disease and stroke, cancer, homicide and accidents, cirrhosis, diabetes and infant mortality, as well as other concerns including teen pregnancy, mental health, chemical dependency, sexually transmitted and communicable disease incidence, lead poisoning, long term care, and access to and utilization of health care resources.

4. Report/Recommendations

The Commission shall provide an interim report by December 1, 1986, and a final report by October 1, 1987.

GIVEN Under My Hand and the Great Seal of the State of Maryland, in the City of Annapolis, this 26th day of March, 1986.

Harry Hughes
Governor

ATTEST:

Lorraine M. Sheehan
Secretary of State

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INTRODUCTION

On the 26th of March, 1986, Governor Hughes signed executive order 01.01.1986.05 creating the Commission on Black and Minority Health. The 27 member Commission was charged with conducting "a thorough examination of the programs and laws relating to the health status of Maryland's minority citizens" as well as to identify and examine limitations and problems associated with existing laws and programs related to the health status of minorities. Additionally, the Commission was directed to examine the causes of, and develop strategies to address, the problem of homicide among young blacks. Finally, the Commission was given broad responsibility to identify and review prevention strategies relating to the leading causes of death among minorities.

The executive order directed the Commission to make a preliminary report to the Governor by December 1, 1986 and a final report by October 1, 1987. To work toward meeting these objectives, the Commission took several actions. First, public hearings were held in five different areas of Maryland where minority populations in significant numbers reside. The purpose of these hearings was to receive comments from the general public, frontline providers, and others concerning the unmet health care needs of minority communities. At each of the public hearings it was announced that the Commission would be dividing into task forces for the purpose of developing recommendations, to be included in the preliminary report, that would seek to address the most immediate health care problems faced by blacks and minorities. Each task force was chaired by a team of commissioners and included individuals from the general public, health care providers and professionals, and any other interested persons who wished to work with the Commission through the task force structure.

Seven task forces were created, each with a specific area of responsibility corresponding to the requirements set out in the executive order. The seven task forces were:

The Task Force on Cardiovascular Disease, Cancer, and Other Causes of Minority Mortality and Morbidity;

The Task Force on Homicide, Suicide, and Unintentional Injury;

The Task Force on Substance Abuse;

The Task Force on Finance, Access, and Indigent Care;

The Task Force on Aging and Mental Health;

The Task Force on Maternal, Child and Family Health Issues; and

The Task Force on Minority Health Manpower Development.

The task forces were asked to develop recommendations for consideration by the full Commission for inclusion into its preliminary report and to identify specific areas of concern for further study. The Commission considered the recommendations made by the task forces and adopted only those recommendations that it considers to be the most crucial to the

improvement of the health status of minorities in the short term. The Commission also identified those areas that it feels require further study for the purpose of developing appropriate programs, or the adjustment of existing programs, to improve the health of blacks and minorities.

The Commission on Black and Minority Health has been given a tremendous task. The provision of health care in today's society is complex and addressing the problems of health status and access to services faced by minorities is difficult in a world of imperfect information and resource limitations. However, the Commission believes that the recommendations it has put forward in the following pages will contribute to solving these problems.

INTERIM RECOMMENDATIONS OF THE COMMISSION ON BLACK AND MINORITY HEALTH

Recommendation 1

The Governor, the General Assembly and the Secretary of the DHMH should expand eligibility for Medicaid by covering all pregnant women and all children under the age of 5, who fall below the poverty level as allowed by the Sixth Omnibus Budget Reconciliation Act of 1986.

In Maryland, as well as nationally, over the past 40 years, the minority infant mortality rate has consistently been at least twice as high as the white rate. However, while both the total and statewide white infant mortality rates have declined or remained stable, the black infant mortality rate has started to fluctuate. The most recent vital statistics data for Maryland indicate that between 1984 and 1985, the black infant mortality rate increased by 16% rising from 16.6 to 19.2 infant deaths per 1,000 live births. Concomitantly, the white rate remained stable at 9.0. The reasons for this disparity remain unclear.

Minority babies in Maryland are also twice as likely as white babies to be born underweight (i.e. under 5.5 pounds). Low birthweight babies as compared to heavier babies are twenty times more likely to die. Between 1984 and 1985 in Maryland, there was a 5% increase in the percentage of black low birthweight births and a slight decline in the percentage (2%) of births to black teenage mothers.

In 1983, eight of the ten states with the highest infant mortality rates in the nation were located in the South. The Southern Regional Task Force on Infant Mortality, on which Maryland was represented, was formed in 1984 to draw attention to the critical problem of infant mortality in the South and to promote preventive measures to reduce its incidence. The Task Force concluded that "we can have a significant impact on infant death and illness and the associated costs if we invest in our future through preventive prenatal and infant health care." A recent Institute of Medicine study similarly concluded that:

> "...the overwhelming weight of the evidence is that prenatal care reduces low birth weight. This finding is strong enough to support a broad, national commitment to ensuring that all pregnant women, those at medical or socioeconomic risk, receive high quality care...(Further,) prenatal care is most effective in reducing the chance of low birth weight among high risk women, whether the risk derives from medical factors, sociodemographic factors, or both."

As a result of the recent passage of the 1986 Federal Budget Reconciliation Act, state Medicaid programs are now allowed to cover women during pregnancy (and during the 60 day period following pregnancy) and/or children under the age of 5, who fall below the federal poverty level. It is estimated that at least 50% of the individuals eligible for this program are minorities.

Both the General Assembly and the DHMH have previously shown their commitment to serving these two populations by including funds in the State's FY 1987 budget to implement a new state-only funded program entitled the "Prenatal Assistance Program". This program was originally designed to serve all poor pregnant women and infants, but for a variety of reasons initially focused on pregnant adolescents. The program currently covers all

pregnant women 21 and under and infants up to the age of 3 months, with family incomes below the poverty level. Benefits include prenatal and postnatal care, the physician's delivery fee, and preventive EPSDT benefits for eligible infants. The objective is to reduce financial barriers to care created by low income and lack of health insurance for the two populations, (i.e., pregnant women and poor children) studies have shown are most likely to benefit from preventive and primary care services. The new federal legislation will allow the State to receive federal matching funds to cover beneficiaries enrolled in this program as well as to expand the program to poor pregnant women of all ages and children up to the age of five.

Recommendation 2

The General Assembly should direct the Secretary of the DHMH to assess the impact of the Department's current ability to pay scale on access to maternity and infant care services offered through local health departments. To improve access to services, the Secretary should also be directed to implement changes to the schedule and the Department's fee policy which would reduce the amount that individuals between 100 and 200 percent of the poverty level must pay.

Recommendation 3

The General Assembly should direct the Secretary of the DHMH to include the first prenatal care and infant care visits on the list of non-chargeable local health department services. Once implemented, this policy should be widely advertised by local health officers.

In 1985, between 2700 and 4440 expectant Maryland mothers received late or no prenatal care. Almost three fifths of these women were black or other minorities. Although there are a variety of reasons why pregnant women do not receive prenatal care, it is the belief of this Commission that the current local health department ability to pay scale serves as one deterrent to the use of services.

Maternity services are currently offered through 22 of Maryland's 24 local health departments found in each subdivision of the State. Current regulations direct the Secretary of the DHMH to set charges for services based on costs. The costs of maternity services depend upon a variety of factors and vary according to county. Current charges range from a low of $26 per visit in one county to a high of $93 in another.

Fees are charged for maternity clinic services on the basis of ability to pay. A sliding fee or ability to pay scale is revised annually by the Secretary. This sliding fee scale depicts the percentage of the fee a client with a given income or family size will pay. Under the Department's current ability to pay schedule, individuals who fall below the poverty level, either are covered by Medicaid or are not charged for services. Individuals with incomes between 100-200% of the poverty level, pay between 10-100% of the clinic charge.

Anecdotal information suggests that the amount of these maternity clinic fees may serve as a deterrent to the receipt of early and continuing prenatal care. In some cases, when potential patients call the clinics to inquire about maternity clinic services, the quoting of fees over the

telephone may also serve as a barrier to the use of services. It is therefore recommended that local health departments be mandated to provide the initial prenatal and infant care visits at no charge to allow clinic staff and patients to assess the client's ability to pay in person. Local health department personnel should also be encouraged to inform patients of their right to obtain services regardless of ability to pay as mandated in current law.

Recommendation 4

The General Assembly should support the development of a comprehensive policy to discourage smoking. Elements of this policy should include: 1) the restoration of funds within the Department of Health and Mental Hygiene for smoking cessation programs as a primary prevention priority of the Department and 2) the establishment of designated smoking areas in public buildings.

It is widely recognized that smoking is a major factor associated with cardiovascular disease, cancer and negative pregnancy outcomes, particularly low birth weight. Smoking also exacerbates hypertension. In Maryland, cigarette smoking results in $471 million dollars a year in health care costs. In addition to death and disability, this can be viewed as an economic loss since only $69 million dollars in revenue is raised each year from the State cigarette tax and $38 million is generated in farm income from tobacco.

While smoking is the most preventable cause of disease, it remains prevalent among the total population and especially among minorities. Forty seven percent of black males in Maryland smoke versus 33% of white males. Thirty-eight percent of black females smoke versus 31% of white females.

Much of the promotion of smoking is targeted to blacks with "good results" for the marketers and disastrous results for the minority population. Cigarette companies have been a reliable source of revenue for black publications, accounting for as much as 11% of the advertising space in some publications.

In previous years, Statewide legislation to limit smoking in retail stores, restaurants and State office buildings has failed. Also, smoking cessation programs for State employees have not been fully funded. The Commission recommends that these actions be taken as well as other activities to reduce smoking in the general population, particularly among youth and pregnant women. Public health clinics, school health programs and voluntary organizations should all promote smoking resistance. The media should also reduce advertising aimed at minorities.

Recommendation 5

The Commission urges increased efforts to educate the public in order to reduce high risk behaviors (smoking, drugs and alcohol abuse) and the spread of AIDS and other sexually transmitted diseases.

Public education can be facilitated by:

1) The expansion of community-based networks (churches, clubs, etc.) to provide peer counseling; 2) the promotion of health education curricula in the public schools and; 3) the development of professional education programs to improve health care providers' communication skills and sensitivity to cultural differences when dealing with minorities.

The Commission is extremely concerned over the growing AIDS (Acquired Immune Deficiency Syndrome) epidemic in the black population. As of July 30, 1986, there were 362 reported cases of AIDS in Maryland, 179 (49.4%) of these occurred in blacks. The rate of positive antibody tests for AIDS in black males is three times that in white males, the rate in black females is 12 times that in white females. Treatment centers particularly hospices should be established so that victims of AIDS can be treated humanely.

The most effective weapon against AIDS and other preventable diseases is education. The Department of Health and Mental Hygiene and the Department of Education should promote the development of peer resistance programs to bring about behavioral change in youth as well as the full implementation of school curricula that include sex education and information on the consequences of using cigarettes, drugs and alcohol. Further, community networks have been shown to be effective means to spread information in minority populations. These programs should begin to address high risk behaviors in the elementary school years to most effectively prevent their occurence. Community networks have also been shown to be an effective means for conveying information within minority populations. Minority street outreach programs should continue to enlist community members in developing posters, printed materials and media announcements on AIDS and other sexually transmitted diseases. Materials distributed should be targeted to specific at risk populations.

Finally, it is necessary for health care professionals to better understand the problems of minorities. Poverty, unemployment, underemployment and access to care play an important role in the availability of quality care. Sensitivity among providers to these social problems is a beginning toward having these problems addressed. Increased awareness of practitioners can lead to improved communication skills with minorities and, consequently, to better care.

Recommendation #6

The General Assembly should provide funding for respite care programs which should assist in preventing the inappropriate institutionalization of black and other minority elderly.

Long term care services are currently provided and financed by both formal support systems, such as federal and state government programs and informal support systems, such as the elderly themselves and their families. While governmental and private sector agencies are heavily involved in the provision of services, several recent national surveys indicate that families and friends are the primary caregivers to the elderly, particularly in minority communities.

Community based services, such as respite care programs, are needed to encourage and support the use of informal sources of care and thereby avoid the inappropriate institutionalization of the impaired elderly. Respite care refers to in-home or other care designed to temporarily relieve the caregiver. A substantial number of the elderly and their families are in need of such services in Maryland. There are currently no publicly funded respite care programs in Maryland which means that low income families have very limited or no access to such services. Blacks and other minorities are disproportionately found in the low income population.

Recognizing the important role that families play in maintaining elderly black and minority persons in the community, the Commission supports the development of community based programs which help minority caregivers better cope with the caregiving situation.

Recommendation 7

The Department of Health and Mental Hygiene should continue to monitor and address racial disparities in the use of nursing home services by the elderly within the Maryland Medicaid Program.

A 1982 study of racial differences in use of health services within the Medicaid Program indicated that the most significant difference was in the use of nursing home services by black and white enrollees aged 65 and over. In FY 1982, white Medicaid enrollees were nearly two and a half times more likely to receive nursing home care as compared to black elderly enrollees of the same age. The exact reasons for this disparity remain unclear. The Commission strongly supports the continued monitoring and development of efforts to address this disparity.

Recommendation 8

The General Assembly and the Department of Health and Mental Hygiene should provide funding to enable public schools to hire health professionals to identify and treat children who exhibit or are at risk of acquiring mental health problems.

There is currently no uniform system in Maryland for identifying and referring children who exhibit or are at risk of acquiring mental health problems. Mental health problems include substance abuse, psychiatric problems and other psychosocial disorders. At risk children include children living in single parent families, those born to teenaged mothers, children living in poor families, victims of child abuse and individuals whose parents are substance abusers.

Black children as compared to white children are twice as likely to be born to a teenaged parent, three times as likely to be poor, three times as likely to die of known child abuse and twelve times as likely to live with a parent who never married. The Commission believes that programs which promote the early detection and treatment of mental health and psychosocial problems among children should be developed and expanded.

Recommendation #9

The Department of Health and Mental Hygiene should work with local health departments, hospitals, physicians, insurers, other health care providers, and the General Assembly to develop innovative means to finance care for the medically indigent and the working poor, including an examination of new sources of revenue, pooling approaches, and special programs.

U. S. Census Bureau estimates indicate that of the 404,560 individuals in Maryland with income below the poverty line, 198,493 (49.1%) are black. In other words, 20.7% of the black population lives under poverty. Census data also shows that 13.2 percent of Maryland's population has an income level that is at 125 percent of the poverty level. Solid data on the number of other minority individuals below poverty was not available.

Additionally, the 1982 Maryland Household Survey reveals that only 78 percent of black males and 82 percent of black females reported having insurance coverage for hospitalization as compared to 91 percent and 90 percent for white females and males respectively. Uninsured admissions accounted for 8.5 percent of all hospital admission in 1984 and Medicaid admissions were 11.1 percent of total admissions, according to the Maryland Center for Health Statistics.

Federal data for fiscal year 1982 indicates that only 50 percent of the persons below the poverty level in Maryland are covered by the State's Medical Assistance Program.

It has been estimated that over 300,000 Maryland residents have no health insurance, public or private, and an additional ten percent are underinsured. (Gold, 1983) Additionally, both studies conducted at the state and national level indicate that as income decreases the chance of being uninsured increases. (Swartz, 1985; Gold, 1983) For example, Swartz has used national data to show that 33 percent of the families below the poverty level have no insurance compared to 7 percent of families with incomes below the poverty limit. (Swartz, 1985)

Under the all-payor system hospitals are reimbursed for a portion of the uncompensated care provided; however, physicians and other nonhospital providers do not enjoy a similar arrangement. Consequently, they have no incentive to provide health care services to uninsured individuals. This, in turn, may result in an increased reliance on hospital emergency rooms as the primary care provider or in the deferral of preventive or early intervention health care services, both of which add significant costs to the provision of health care services.

One possible means of improving access may be to consider changes in coverages under the Maryland Group Health Insurance Plan Act. It may be desirable to create a group health plan similar to the Medicare Part B program to cover non-hospital services for eligible individuals. Additionally provision could be made to include a sliding scale type of copayment/premium arrangement that would provide an incentive for otherwise eligible individuals to elect to receive benefits under the Plan.

Recommendation #10

Recognizing that malpractice insurance and contingent liability costs are issues which currently and prospectively deny access to medical services, the General Assembly is urged to consider further tort reform. Further, health care providers are urged to develop and enter into creative partnership arrangements that will improve access to medical services by pooling the risks and costs of medical liability.

The Commission has become aware of incidents in which physicians have refused to treat Medicaid and uninsured patients ostensibly because of fear of the consequences of medical liability. While all of the facts are not yet available, the issue concerns the lack of availability of blanket coverage for physicians who are "private contractors" either with the State, local health departments, or hospitals. The issue appears to be of crucial importance in rural areas and in those hospital settings in which there are no staff physicians.

Recommendation 11

The Commission urges strongly that every effort be made to raise the consciousness of the public, generally, and health care providers, educators, religious leaders, individuals who work with youths, and other community leaders, specifically, to recognize homicide and unintentional injuries as serious health issues. Strategies should be developed that are aimed at prevention; that can serve as intervention measures; and that can prevent a reoccurrence of the problem, (i.e., postvention strategies). These strategies should include input from resources that can be found in the family, the churches, the educational system and the public health system as well as those of the traditional criminal justice system.

Homicide is the leading cause of death for black males ages 13 to 34 years and black females ages 15 to 24 years. Homicide is almost seven times more likely to be the cause of death for black males than for white males and three and a half times more likely for black females than for white females. Violence is the prime killer of blacks and other minorities and it kills them in the prime of their lives. Unfortunately, however, violence is still viewed by many as a criminal justice and social problem instead of the public health crisis that it has become. Thus, the criminal justice system has been virtually left alone to grapple with the problem of violence and homicide with little success. Moreover, many find it difficult to perceive homicide studied in a public health context since, for so long, it has been viewed in a criminal justice or other sociological context. Nevertheless, homicide is a public health problem. It is a public health problem because it is one of the leading causes of death, particularly premature mortality, in America.

Ideally, a public health perspective would involve disparate community, academic and governmental agencies and groups working together and separately in a coordinated but multifaceted, multilevel, long-term strategy to combat the multifaceted and complex problem of violence. Recognizing this, the Commission suggests that strategy development conjoins services and resources in the medical and mental health fields, the criminal justice sector, the public education system and social service agencies.

Injuries are the fourth major cause of death overall in the United States and the leading cause of death for Maryland's black population from ages 1 to 44. Injuries affect all ages, but especially the young and the old and the lower socioeconomic groups. Yet, the perception of injuries or accidents as a public health problem is not clear and, therefore, receives little attention. The Commission recommends that the appropriate agencies seriously conduct research to refine the perception of injuries as a public health problem and to develop strategies to prevent those accidents that result in loss of life or productivity.

Recommendation 12

The Commission recommends that data banks be established so as to ascertain the characteristics of substance abusers. Further the Commission recommends that a systematic process for data collection and data sharing be developed to establish the point at which a client enters or leaves one system of treatment for another system of treatment.

There is little hard data on the incidence and prevalence of substance abuse among the State's minority populations. Generally, the data do not include race or ethnicity as variables. Although data collection and its distribution has improved in recent years, there is a gap in the ability of the health, social services and law enforcement communities to collect and share data in order to coordinate their services. Under the current structure, different agencies are not made aware of the instances when the same individual goes from one to the other and each must start from the beginning with evaluation and treatment.

Recommendation 13

The Commission recommends the immediate infusion of public money to establish new substance abuse prevention and treatment programs and to bolster existing treatment programs. At the minimum funding, for prevention should at least be equal to funding for treatment.

The Commission finds that there are an insufficient number of treatment slots for those individuals seeking treatment. Additionally, the type of treatment program offered does not necessarily reflect the particular type of substance abuse prevalent in a particular community. Finally, while treatment of substance abusers is a necessary element to addressing the problem, preventing involvement with drugs, alcohol and tobacco should be at least as equally high a priority. The Commission sees the emphasis upon prevention programs as seriously weak. The schools, the public health community and the law enforcement agencies fall far short in removing illegal drugs from the community and in educating children and adults to avoid drugs, alcohol and tobacco.

Recommendation 14

The Commission recommends that the necessary research, data collection and analysis be carried out to formulate recommendations in the area of minority health manpower.

Preliminary data reveal that Blacks and other minorities are underrepresented in the health professions and in senior managerial and policymaking positions throughout the health industry as compared to their percentages in the total population. These disparities are of great concern since the adequate representation of blacks and minorities in the health professions and in health policy decisionmaking positions is viewed as an integral part of improving minority health status.

Available data for Maryland also show that blacks, and to some extent, hispanics, and Native Americans are underrepresented in the health professions. The most recent physician licensure data for the years 1983-4 and nursing licensure data for the years 1984-5, show that blacks represented 5% of physicians, 6% of registered nurses and 31% of licensed practical nurses. Hispanics comprised 2% of physicians and registered nurses and less than 1 percent of licensed practical nurses. Native Americans constituted less that 0.1% of physicians, 0.1% of registered nurses and 0.3% of licensed practical nurses. Asian/Pacific Islanders represented 14% of physicians, 2% of registered nurses and less than 1 percent of licensed practical nurses. Recent licensure data for the remaining licensed professions by race are currently unavailable.

Maryland's health care industry consists of numerous public and private organizations concerned with health, including hospitals, insurers, nursing homes, medical and dental labs, public health departments, regulatory agencies and ambulatory care facilities. However, very little is currently known about black and minority employment in Maryland's health and insurance industries. Preliminary data available through the U.S. Equal Opportunity Employment Commission for 1984 and the Maryland Department of Health and Mental Hygiene for 1986 show that black and minority employment in senior level policy and managerial positions is disproportionately low in many subdivisions. In both the public and private sectors, blacks and Hispanics

are underrepresented in the managerial and professional categories and overrepresented in clerical, blue collar and service positions. Conversely, Asian/Pacific Islanders and whites tend to be overrepresented in the managerial and professional positions and underrepresented in clerical, service and blue collar positions.

Very little is also currently known about the practice patterns of minority health professionals in Maryland. Preliminary findings suggest that blacks and minorities are significantly more likely to practice in minority and medically underserved areas, whether by choice or for other reasons. Hence, the availability of increased numbers of black and minority health professionals should ultimately result in greater access to health services in minority communities and consequently, improvements in health status. This relationship is dependent upon adequate reimbursement for the quality and quantity of services needed by these communities. Similarly, increased numbers of blacks and minorities in managerial and policy decision making positions provide a greater opportunity for the minority perspective to influence health care delivery policy decisions.

Recommendation 15

The General Assembly and the Department of Health and Mental Hygiene should provide funding for data collection and special studies to investigate the factors which influence black and minority health status and access to health services in Maryland.

In order to develop appropriate strategies to address continuing minority/white differentials in health status in Maryland, a better understanding of the health needs and problems of blacks and minorities is required. Throughout this interim period, the Commission has continually found that existing data and information concerning the health problems, needs and utilization patterns of blacks and minorities in Maryland to be inadequate.

The major sources of data for natality mortality and morbidity statistics are birth and death certificates which are analyzed and reported annually by the Maryland Center for Health Statistics. Information on the race of the individual is requested on both certificates. The most recent published reports generally display the data according to racial groupings, most commonly "white and nonwhite" or "white, black and other."
Data which describe American Indians and Asian/Pacific Islanders are available but usually are not published. However, ethnicity is currently not recorded on birth or death certificates in Maryland. Since hispanics are generally recognized as an ethnic group and not a racial group, vital statistics for this population are currently unavailable.

In some cases, prevalence and incidence data for certain diseases and conditions (e.g. substance abuse and mental health problems) are not available by race. Many publicly and privately funded health programs do not collect utilization data by race. In addition, information concerning the recruitment, training and employment of blacks and minorities in the health field in Maryland is sorely lacking. Finally, studies which evaluate the effects of Maryland health programs and strategies on minority health status are almost nonexistent.

The Commission recommends that the following special studies and data collection efforts be funded:

- A determination of the prevalence and incidence of selected conditions by race, including mental problems and drug abuse;

- An evaluation of the impact of current publicly funded programs on the health of minorities and access to and use of health services, including maternal and child health programs, services for the elderly, violence prevention programs, substance abuse programs, disease prevention and treatment programs and mental health services;

- An examination of the effects of health beliefs and lack of knowledge of resource availability on access to and use of health services among Maryland's minority populations;

- An analysis of differences in health status within Maryland's population by socio-economic status;

- An analysis of the characteristics of Maryland's uninsured population by race;

- An identification of documented effective methods for increasing minority access and use of health services, including health education and outreach programs; and

- An analysis of the recruitment, training, hiring and promotion experiences of blacks and minorities in Maryland's health and insurance industries.

ISSUES REQUIRING FURTHER STUDY

The Commission's seven task forces have identified issues requiring further study prior to delineation of final Commission recommendations. These areas are outlined and summarized below.

Task Force on Minority Health Manpower Development

The Task Force on Minority Health Manpower Development plans to examine the status of blacks and minorities in the following health professions, health occupations and related areas (groups are listed in alphabetical order):

Dental Hygienists, Dental Laboratory Technologists, Dentists, Health Administrators and Managers (Public and Private Sector), Health Facility Boards and Commissions, Health Planners and Policy Analysts, Medical Laboratory Technologists, Nurses, Occupational Therapists, Optometrists, Pharmacists, Physical Therapists, Physicians, Podiatrists, Psychologists, Radiological Technologists, Social Workers and Speech Pathologists and Audiologists.

To assist in the development of the Commission's recommendations, the Task Force will attempt to identify and/or assess the following:

- The relationship between the numbers of black and minority health professionals and the health status of blacks and minorities as measured by general morbidity and mortality indicators and access to health services;
- The social and health characteristics of Maryland's minority communities, including an examination of the availability and utilization of health resources;
- The characteristics of minority practitioners and health professions students in Maryland;
- The effectiveness of Maryland programs designed to (1) enhance and support black and minority participation in the health professions at the elementary, secondary and postsecondary levels, and to (2) increase minority representation in managerial and policy decision-making positions in the health and insurance industries;
- Perceived and documented barriers to (1) the recruitment, retention, graduation, licensing and/or employment of black and minority practitioners and health professions students in Maryland, and to (2) the hiring and promotion of blacks and minorities in Maryland's health and insurance industries;
- The potential impact of current and projected changes in the health care delivery system on the status of blacks and minorities in the health professions;

Task Force on Homicide, Suicide and Unintentional Injuries

Over the next several months, the Task Force on Homicide, Suicide and Unintentional Injuries is charged with examining the causes of homicide, suicide, and unintentional injuries in black and minority communities and developing strategies and recommendations to reduce the incidence of these problems.

In addressing this charge, the Task Force plans to:

- develop and study measures that could reduce the incidence of firearm abuse;
- identify and evaluate strategies designed to detect and prevent homicide;
- evaluate the effectiveness of current programs and services for youth which are designed to prevent and treat juvenile delinquency and/or violent behaviors, including the Reasoned Straight Program; and
- study ways to improve and/or strengthen home safety, motor vehicle safety, and drunk driving and speed limit laws.

Task Force on Cardiovascular Disease, Cancer and Other Leading Causes of Minority Morbidity and Mortality

This Task Force is charged with examining racial disparities in the incidence and prevalence of selected major diseases and conditions, identifying problems in the prevention and treatment of these diseases and developing recommendations to alleviate these problems. In the coming months, the Task Force plans to:

- prioritize numerous recommendations considered over the past months;
- identify model to be used in implementing programs to decrease the incidence and prevalence of cardiovascular disease, cancer and other diseases and conditions which disproportionately affect blacks and minorities; and
- inventory community health resources and develop centralized points for accessing this information.

It is hoped that these activities will lead to a reduction in disease and disability among minorities and to greater awareness of potential risk behaviors in future generations.

Task Force on Substance Abuse

- The Task Force will continue to collect and analyze data from a variety of sources as resources permit.

- The Task Force plans to study the development of a broad program of health education from the earliest grades until graduation. The Task Force hopes that the education community will cooperate with us on this issue. The Task Force will also continue to pursue cooperation with other groups promoting these goals, such as the Maryland Bar Association's Special Committee on Adolescent Alcoholism, Addiction, and Alcohol and Drug Abuse.

- The Task Force on Substance Abuse, perhaps in cooperation with the Task Force on Minority Health Manpower Development, will develop requirements and guidelines for adequate minority representation in substance abuse treatment and prevention programs.

- The Task Force will continue to study the various barriers to treatment access, including language barriers, insurance, the certificate of need procedure, the location of facilities, and attitudinal problems.

- Greater attention needs to be focused on program accessibility and community needs. Relative to that focus, some evaluation of treatment programs will be necessary.

- The Task Force will study the issue of the attraction of tobacco use among the young and consider such recommendations as school-based programs, a strong initiative by the Department of Health and Mental Hygiene, and strong anti-smoking legislation.

- The Task Force has been informed that prescription drug overuse is a growing problem among the elderly in minority populations. The Task Force will consider possible remedies to this problem.

- The Task Force will attempt to ascertain whether there are new approaches to treatment that would meet with greater success in the minority communities.

Task Force on Finance, Access and Indigent Care

During the next several months this Task Force will attempt to develop a strategy for providing health care coverage to the uninsured and the working poor who are unable to obtain medical services. The Task Force will examine other states' initiatives in its attempt to develop an innovative means of financing health care for the medically indigent.

APPENDIX A

BLACK AND MINORITY HEALTH IN MARYLAND: AN OVERVIEW

BLACK AND MINORITY HEALTH IN MARYLAND: AN OVERVIEW

INTRODUCTION

Over the past several decades, there has been a voluminous amount of data that highlights health status disparities between minorities and non-minorities, and the poor versus the non-poor. For the most part, these data have suggested that on average, whites are healthier than minorities and that the non-poor are healthier than the poor. For example, on average, minorities as opposed to whites:

- have higher age adjusted mortality and morbidity rates;
- are more likely to report fair or poor health status; and
- are less likely to be insured.

The recent DHHS Secretarial Task Force on Black and Minority Health once again documented higher morbidity and mortality rates for blacks and other minorities as compared to whites and refocussed national attention on this issue. Over one hundred recommendations covering the areas of health information and education, delivering and financing health services, health professions' development, cooperative efforts with the non-Federal section, data development and research, were proposed by the Task Force.

Similarly, several recent reports and analyses have focused attention on racial differences in the health status of Marylanders. First, in 1984, the Center for Health Statistics within the Maryland Department of Health and Mental Hygiene published the first edition of Health Maryland, an annual series on the health status of Marylanders. The 1984 report showed that tremendous improvements in the health of Maryland's population have occurred since 1940, as evidenced by declining infant mortality rates and death rates from communicable diseases such as tuberculosis. However, the report also highlighted racial differentials in health status and access to health resources. Secondly, over the past several years, Medicaid data has consistently documented that within the Medicaid program, there are racial differentials in payment and utilization levels. Finally, continuing federal cutbacks in health care spending have caused concern that access to public health programs which serve a large percentage of the medically indigent will continue to diminish and cause further deterioration of the health status of the poor and minorities. The Governor's Commission on Black and Minority Health was formed to address these and other concerns around health disparities by race.

WHO ARE MARYLAND'S RACIAL MINORITIES?

As Table 1 shows, racial minorities represent 25% of Maryland's total population. Maryland's minority representation is 50% higher than the U.S. average of 17%. Twenty three percent of Maryland's population is black, while only 12% of the U.S. population is black. According to the 1980 Census, less than 3% of the population is composed of non-black minorities including Asian/Pacific Islanders (1.5%), Native Americans (0.6%) and others (0.6%). Blacks comprise the majority of Maryland's minority population as Figure 1 shows. The Census Bureau identifies individuals of hispanic descent as a separate ethnic group, independent of race. These individuals may be of any race (e.g., white, black, Asian). According to 1980 Census, there were 67,746 individuals of hispanic descent living in Maryland. Over 40% of Hispanics were Mexican, Puerto Rican or Cuban.

TABLE I

MARYLAND'S POPULATION BY RACE, 1980

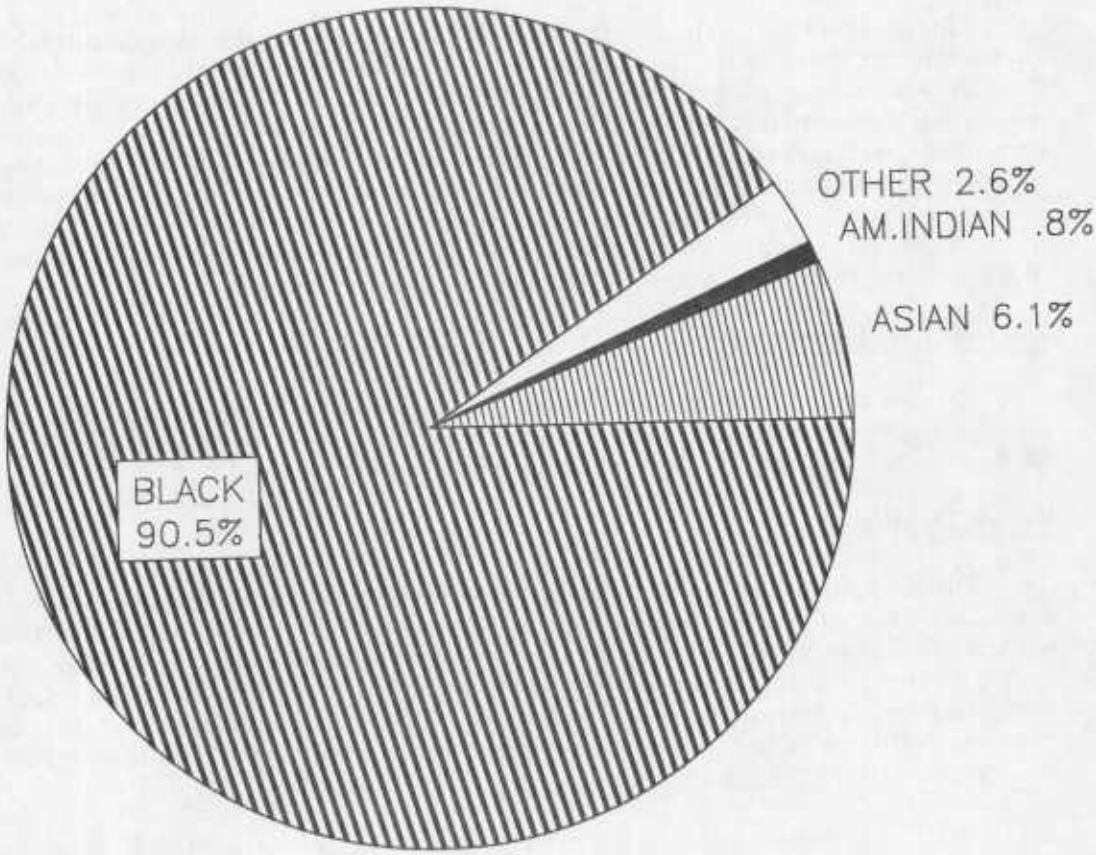
Race	Maryland Number	Maryland %	U.S. %
Total	4,216,975	100.0	100.0
* White	3,158,838	74.9	83.4
* Minorities	1,058,137	25.0	16.6
• Black	958,150	22.7	11.6
• Asian/Pacific Islander	64,278	1.5	1.6
Korean	15,089		
Chinese	14,485		
Asian Indian	13,705		
Filipino	10,965		
Japanese	4,805		
Vietnamese	4,131		
Hawaiian	616		
Guamaniam	400		
Somoan	82		
• Native American	7,823	0.1	0.6
• Alaskan Native	198	0.0[a]	0.0[a]
• Other	27,688	0.6	2.8

Source: U.S. Census Bureau, 1980

[a]Less than 1/10 of 1%

FIGURE I

PERCENT DISTRIBUTION OF
MINORITIES BY RACE IN MARYLAND, 1980



Source: 1980 U.S. Census

Between 1970 and 1980, Maryland's minority populations increased by 45% from 0.7 to 1.1 million. During this same time period, there was a 1% decrease in Maryland's white population.

The geographic distribution of minorities in Maryland varies by racial grouping. As a whole, the majority (90%) of minorities reside in the Central Maryland and Suburban D.C. regions. This is displayed in Figure 2.

WHAT ARE THE MAJOR HEALTH DISPARITIES BY RACE?

Health and health status are difficult concepts to define and quantify. The most commonly accepted definition of health is provided by the World Health Organization (WHO). According to WHO, health is defined as ".... a state of complete physical, mental, and social well being and not merely the absence of disease." The most commonly used and readily available indicators of health status are mortality and morbidity statistics. These data are used to derive indicators such as average life expectancy, age adjusted mortality and morbidity rates, excess deaths, and "relative risk of death." The indicators show that significant health disparities exist by race in Maryland and the U.S. The major disparities are discussed below.

Average Life Expectancy

On average, minorities die at younger ages than non-minorities. As Table 2 shows, on average, a minority baby born in Maryland in 1980 will live four years less than a white baby. The disparity is even greater for males.

Excess Deaths

Minority Marylanders also die at higher than expected rates. Age-adjusted death rates for seven of the ten leading causes of death are higher among minorities than whites. As Table 3 and Figure 3 show, age adjusted death rates are higher for minorities versus whites for heart disease and stroke, cancer, homicide and accidents, pneumonia and influenza, diabetes, infant mortality, and chronic liver disease and cirrhosis. Age-adjusted death rates are higher for whites versus minorities for motor vehicle accidents, suicide and chronic obstructive pulmonary disease.

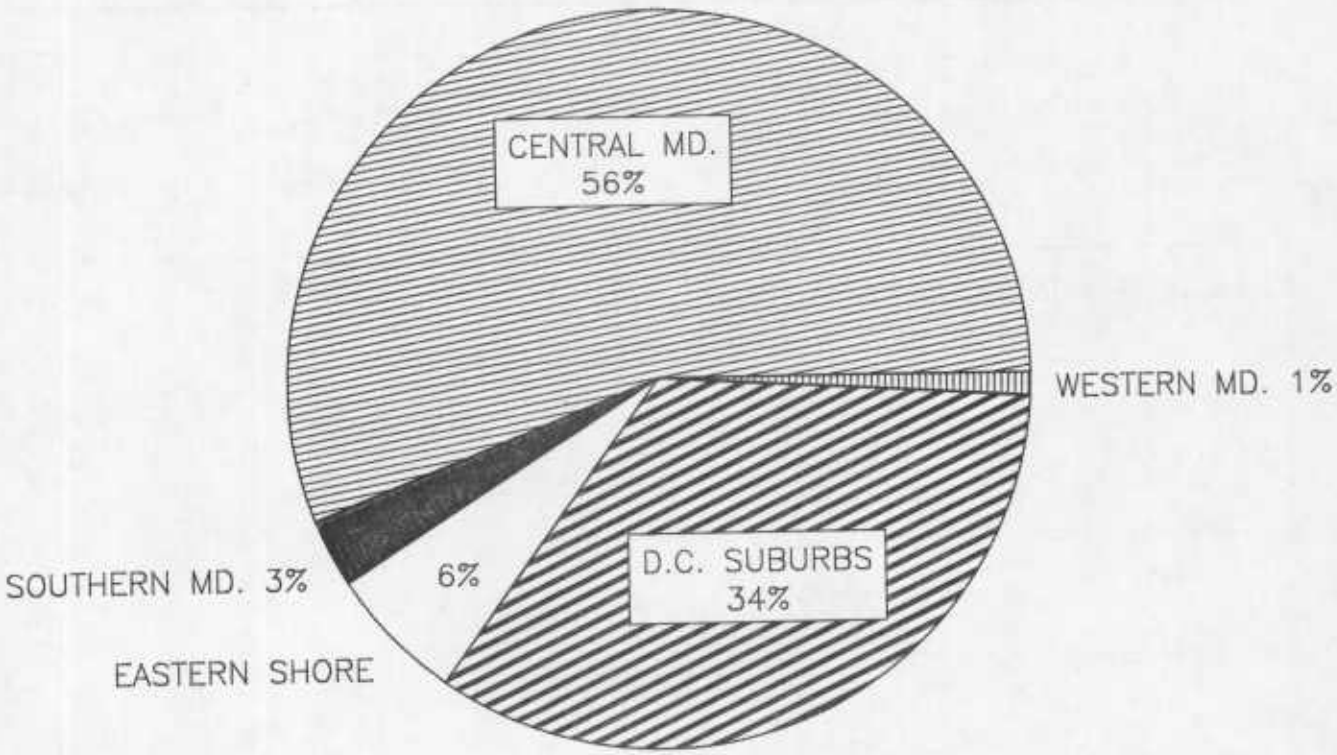
The DHHS Secretarial Task Force on Black and Minority Health found that approximately 60,000 excess deaths occur among black Americans each year. The DHHS defined "excess deaths" as those deaths that would not have occurred had blacks died at the same rate as whites. They also found that 80% of excess deaths result from heart disease and stroke, homicide and accidents, cancer, infant mortality, cirrhosis and diabetes. In 1982, approximately 1,654 "excess deaths" occurred among minority Marylanders. The leading contributors to excess deaths among minorities in Maryland are briefly discussed below.

Heart Disease and Stroke

Heart disease and stroke cause more deaths, disabilities, and economic loss than any other acute or chronic disease in the U.S. or Maryland. It is the leading cause of death across all race/sex categories. Major risk factors include hypertension, cigarette smoking, elevated blood cholesterol, diabetes and obesity. In 1982, the age adjusted death rate from stroke was 70% higher among minority males than white males. The

FIGURE 2

PERCENT DISTRIBUTION OF
MINORITIES BY REGIONS IN MARYLAND



Source: 1980 U.S. Census

TABLE 2

AVERAGE LIFE EXPECTANCY BY RACE IN MARYLAND, 1979-1981

	Total	Males	Females
White	70	71	78
Minority	74	66	74

Source: National Center for Health Statistics

TABLE 3

AGE ADJUSTED DEATH RATES BY
RACE, SEX, AND SELECTED CAUSES, MARYLAND, 1982

(RATE PER 100,000 POPULATION)

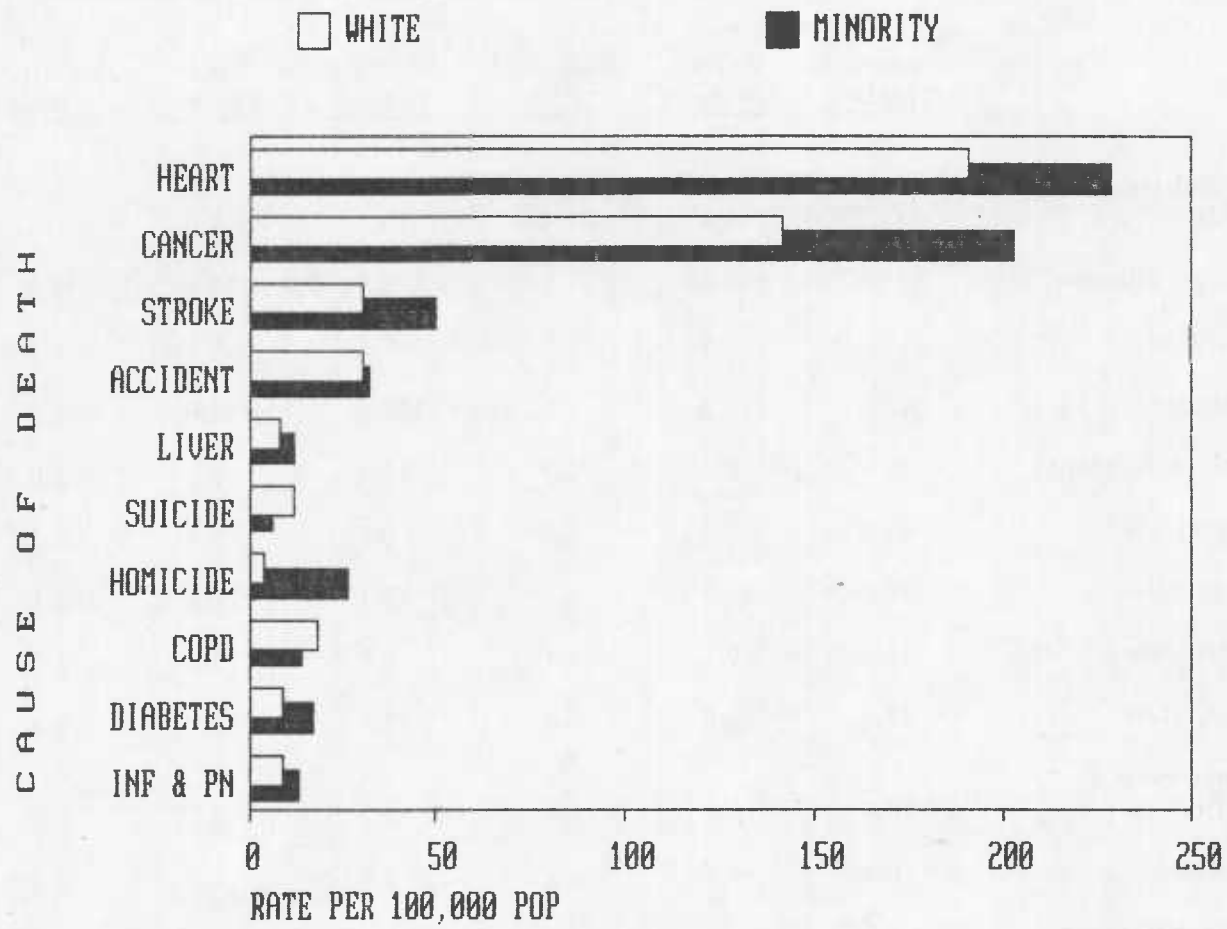
	Minority Male	White Male	Relative[1] Risk	Minority Female	White Female	Relative[1] Risk
Total Deaths (All Causes)	993.7	708.6	1.4	579.7	407.5	1.4
Heart Disease	295.0	263.5	1.1	176.9	134.6	1.3
Stroke	53.6	32.2	1.7	47.5	28.1	1.7
Cancer	271.4	175.5	1.5	152.0	120.0	1.3
Infant Mortality	20.7	8.4	2.5	17.4	5.8	3.0
Homicide	43.6	6.3	6.9	9.9	2.8	3.5
Accidents	48.9	44.0	1.1	18.1	16.1	1.1
Cirrhosis	15.3	10.7	1.4	9.9	5.0	2.0
Diabetes	17.8	10.0	1.8	17.2	8.7	2.0
Pneumona & Influenza	18.4	13.1	1.4	9.4	6.1	1.5
Suicide	10.4	19.1	0.5	2.5	5.6	0.4
Motor Vehicle Accidents	19.1	24.6	0.8	6.5	10.4	0.6

Source: Maryland Center for Health Statistics

[1]Relative Risk is the ratio of the minority death rate to the white rate.

FIGURE 3

AGE-ADJUSTED DEATH RATES BY RACE AND CAUSE OF DEATH IN MARYLAND, 1982



Source: Health Maryland, 1985

* **MINORITIES ARE SUBSTANTIALLY MORE LIKELY TO DIE FROM EACH OF THE THREE LEADING CAUSES OF DEATH -- HEART DISEASE, CANCER AND STROKE -- THAN WHITES.**

* **THE MINORITY DEATH RATE FROM HOMICIDE IS SEVEN TIMES THE WHITE RATE.**

prevalence of hypertension, a major risk factor for heart disease and strake, is 35 percent higher among blacks than whites.

Cancer

Cancer is the second leading cause of death in Maryland. Major risk factors including smoking, diet, alcoholism, accupational hazards, poverty, lack of educatian and inadequate access to medical care. Smoking, alcohol abuse, and nutrition and dietary factors are reported to account for approximately 72% of cancer mortality and 69% of cancer incidence.

Bath minarity males and minority females have higher age-adjusted cancer martality rates than their white counterparts. Far males, the minority death rate far cancer was 50% higher than the white rate in 1982. Since 1980, there has been a sharp increase in cancer deaths among minarity Marylanders. The age adjusted rate increased by 7.9% for minority males and 15.2% for minority females between 1980 and 1982. In contrast, rates declined by 1% amang white males and increased by only 1.3% among white females. The five year cancer survival rate for blacks is lower than the rate for whites.

Diabetes

Diabetes was the seventh leading cause of death in Maryland in 1984. Hawever, diabetes related complications are a major cause of morbidity and mortality, including heart attacks and strokes, kidney failure, new blindness, non-traumatic amputations, and cangenital abnormalities. Major risk factors include age, sex, obesity, diet, lack af physical activity, genetic factors, and pregnancy. Minority females have the highest death rate fram diabetes of all race/sex groups in Maryland. In 1982, the age adjusted rate of death from diabetes amang minority females at 17.2 per 100,000 was twice the white rate of 8.7.

Cirrhosis and Liver Disease

Cirrhosis and liver disease are the eleventh leading cause of death in Maryland. Age-adjusted death rates for liver disease and cirrhosis are higher among minorities than whites. Alcoholism and alcohol abuse are major risk factors for cirrhosis and liver disease. Mortality rate far chronic liver disease and cirrhosis have been falling in Maryland far all race-sex groups except minority females, who showed an increase in rates of 7.6% between 1980 and 1982. The greatest declines have been seen among minarity males, whose death rates declined by nearly 30% during this time period.

Homicide

In 1984, homicide was the twelfth leading cause af death for all Marylanders and the fourth leading cause of death for minorities. Black-on-black homicide has been termed an "epidemic." The report of the DHHS Task Force indicates that "no cause of death sa greatly differentiates Black Americans from other Americans as homicide." In 1984, 383 Marylanders died as a result of homicide. A disproportionate percentage (68%) of homicide deaths occur in the black population.

The death rate for homicide among minority males is seven times the white rate, at 43.6 and 6.3 deaths per 100,000 population in 1982, respectively. Baltimore City has the highest age-adjusted death rate from homicide of any subdivision in the State. Homicide

is also the leading cause of death for black males between the ages of 15 and 34 in Maryland.

The causes of homicide are varied and complex. Physiological, environmental, psychological and lifestyle factors, such as unemployment, substance abuse, poverty, stress, hopelessness, and helplessness are thought to play a role in homicide. Homicide has been thrust into the public health arena because of its link to mental health, alcoholism and drug abuse. Approximately 50% of all homicides are related to the use of alcohol and 10 to 20% of homicides are associated with the use of drugs.

A further examination of morbidity and mortality data show that major differences in health status exist by race according to age groups, namely infants and children and the elderly. These two groups are briefly discussed below.

Maternal and Child Health Status

Minorities, as compared to non-minorities in Maryland, have higher rates of births, teenage pregnancy, infant mortality, low birth weight and premature births. Minority mothers versus white mothers are also three times as likely to receive late or no prenatal care, four times as likely to be unmarried and more likely to be poor. Similarly, according to the Children's Defense Fund, black children as compared to white children are three times as likely to be poor, three times as likely to die of known child abuse, five times as likely to become pregnant as teenagers, and twelve times as likely to live with a parent who never married.

Infant mortality, the rate of infant deaths per 100,000 live births, is generally used as an indicator of the general living standards and health status of a population. In 1983, Maryland had the 12th highest infant mortality rate in the nation. This is surprising finding for a State which has the 7th highest per capita income in the nation.

There is generally a distinction made between infant deaths that occur during the first 28 days of life (i.e., neonatal mortality) and infant deaths occurring between 29 days to one year of life (i.e., post-neonatal mortality). Low birth weight, lack of access to quality prenatal care services, lifestyle habits of the mother and other influences occurring prenatally, at birth or in the newborn period, are closely linked to neonatal mortality. Post-neonatal mortality tends to be associated with a variety of conditions occurring after birth (e.g., lack of infant health services, SIDS, inadequate nutrition or sanitation, or accidental injury). Low birth weight contributes to two thirds of deaths in the neonatal period and approximately 50% of all infant deaths. Babies born to teenaged mothers are more likely to be premature, to have a low birth weight and to die in their first year of life.

In Maryland, as well as nationally, over the past 40 years, the minority infant mortality rate has consistently been at least twice as high as the white rate. However, while both the total and statewide white infant mortality rates have declined or remained stable, the black infant mortality rate has started to fluctuate. The most recent vital statistics data for Maryland indicate that between 1984 and 1985, the black infant mortality rate increased by 16% rising from 16.6 to 19.2 infant deaths per 1,000 live births. Concomitantly, the white rate remained stable at 9.0. The reasons for this disparity remain unclear. However, many of the risk factors associated with infant mortality (e.g., low birth weight, teenage pregnancy, inadequate prenatal care, poverty, limited education) disproportionately occur in black and minority populations.

Minority babies in Maryland are also twice as likely as white babies to born

underweight (under 5.5 pounds). Low birth weight babies as compored to heavier babies are twenty times more likely to die. Between 1984 and 1985 in Maryland, there wos o 5% increase in the percentage of black low birth weight births ond o slight decline in the percentoge (2%) of births to black teenoge mothers.

In 1984, of the 65,264 births in Morylond, 8300 or 13% were to mothers under the oge of 20. A disproportionote number of births to teens ore to minority women. In 1983, blacks comprised 27% of the femole teen populotion ond 51% of the teen births. Block teens ore almost twice os likely to white teens to hove out-of-wedlock births. Teens who become pregnont ore less likely to seek eorly prenatal core or to follow heolth core odvice on motters offecting their pregnancies (e.g., nutrition, obstinence from olcohol ond drugs). The result of mony of these teen pregnoncies is therefore, o low birth weight infont who is ot increosed risk for handicopping conditions or deoth. According to the Children's Defense Fund, "black teen birth rotes are higher thon white rates becouse black teens ore more likely to be sexuolly octive; somewhat less likely to use contraceptives, ond if foced with unintended pregnancies, less likely to obtoin obortions. Holf of oll block unintended teen pregnoncies end in obortion compored with olmost two-thirds of all white unintended teen pregnoncies.

In 1980 there were 1.3 million children ond youth living in Morylond. Thirty percent were minorities. According to the 1980 Census, 48% of black children in Moryland ore poor os compared with 28% of white children. Severol studies hove shown thot poor children hove higher rotes of illness thon non poor children.

Health Status of the Minority Elderly

Americon society is oging and the numbers of elderly are increasing. Over the last two decades, the elderly population hos grown twice os fost of the rest of the populotion. In 1980, 396,000 Morylonders or 9 percent of the populotion wos 65 or older, compored to 11 percent, notionwide. Whites ore disproportionotely represented in Moryland's elderly populotion. Minorities ore 25% of the totol populotion, but only 15% of the elderly.

Morylond's minority populotion hos o smoller proportion of elderly persons thon the white populotion. Eleven percent of whites and six percent of minorities ore oged 65 or over.

Poverty rotes ore much higher among minority elderly thon white elderly. In 1980 in Morylond, the poverty rate omong black elderly (29%) was three times the white rote (10%). Poor minority elderly in Americon society ore soid to suffer from "triple jeopordy" becouse of the discriminotion which results from being oged, minorities ond poor. Quodruple "jeopordy" is used to describe the plight of poor minority elderly women. Within the elderly populotion, poverty rotes are highest omong block elderly women who live olone (61%).

Limited informotion is ovailoble on the heolth status of elderly minorities, particularly in Moryland. Avoiloble informotion does seem to indicote that disparities in heolth stotus by roce vory occording to oge of the elderly. For exomple, overoge life expectoncy ot birth differs occording to roce with whites living longer thon blocks in the U.S. However, differences in life expectoncy by roce ore smoller once on individuol reoches oge 65. At age 80, what hove been termed the "cross-over effect" occurs, whereby life expectoncy is higher for blocks than whites. This finding hos been portiolly ottributed to "hordiness omong survivors in o population thot hos o higher eorly oge death rote."

Similarly, the following Maryland mortality data shows that death rates are higher for minority versus white elderly until age 85+ when the reverse is observed.

Elderly Death Rates Per 100,000 Population From All Causes, Maryland, 1982

	Males		Females	
	White	Minority	White	Minority
Age				
65-74	4150.2	5275.6	2239.5	2985.4
75-84	8782.2	9281.7	5318.7	5898.5
85+	17598.2	16603.8	13551.0	11048.2

Source: Maryland Center for Health Statistics

Much more is known about differential access to and use of health services within the elderly population by race. For example, at any given point in time, approximately 5 percent of the elderly population is institutionalized. However, white Medicaid enrollees are twice as likely to receive nursing home care as compared to black elderly enrollees of the same age. Secondly, on average, Medicare and Medicaid payment levels on behalf of the elderly are higher for whites than minorities. Minority elderly are also less likely than white elderly to have adequate health insurance coverage. Thirdly, according to 1982 health survey data for Maryland, the black elderly are less likely than the white elderly to seek health care services even when they feel it is needed, 36 and 22 percent, respectively. The black elderly in Maryland are also less likely than the white elderly to report having a private physician as their usual source of care, 57 and 83 percent respectively. These reasons for these disparities remain unclear, however, poverty and lack of health coverage are thought to play major roles.

WHAT FACTORS ARE THOUGHT TO CONTRIBUTE TO IDENTIFIED HEALTH DISPARITIES BY RACE?

Exhibit I provides a summary of the factors which are thought to contribute to the observed disparities in health status by race. However, as pointed out by the DHHS Task Force on Black and Minority Health "the factors responsible for the health disparity are complex and defy simplistic solutions. Health status is influenced by the interaction of physiological, cultural, psychological and societal factors that are poorly understood for the general population and even less so for minorities." The potential role of several of these factors is briefly discussed below.

Socioeconomic Status and Health Status

While there is a voluminous amount of data that examines either racial or income differentials in the use of medical services, very few studies or researchers have investigated the simultaneous impacts of both factors on health status and/or utilization patterns. In a review of the literature concerning the contribution of socio-economic

EXHIBIT I

FACTORS CONTRIBUTING TO IDENTIFIED HEALTH DISPARITIES BY RACE

* SOCIO-ECONOMIC STATUS: POVERTY, UNEMPLOYMENT, AND RELATED SOCIAL CONDITIONS
  - MINORITIES ARE THREE TIMES MORE LIKELY TO BE POOR AS WHITES
  - MINORITIES ARE ALSO TWICE AS LIKELY TO BE UNEMPLOYED
* INADEQUTE ACCESS TO AND UTILIZATION OF HEALTH CARE RESOURCES
  - LACK OF HEALTH INSURANCE COVERAGE AND TYPE OF COVERAGE
    - MINORITIES ARE FOUR TIMES MORE LIKELY TO BE MEDICAID RECIPIENTS THAN WHITES
    - BLACKS ARE TWICE AS LIKELY AS WHITES TO BE UNINSURED
  - INADEQUATE PRENATAL CARE
    - MINORITIES ARE THREE TIMES MORE LIKELY TO RECEIVE LATE OR NO PRENATAL CARE
  - LACK OF ACCESS TO PRIMARY CARE AND OTHER RESOURCES PARTICULARLY IN AREAS WITH HIGH CONCENTRATIONS OF POOR MINORITIES
  - HEALTH KNOWLEDGE AND CULTURAL ATTITUDES AND BELIEFS
  - RACIAL DISCRIMINATION
* ENVIRONMENTAL AND OCCUPATIONAL EXPOSURES
* LIFESTYLE/HEALTH RISK FACTORS
  - SMOKING
  - DIET AND OBESITY
  - ALCOHOL AND DRUG ABUSE
* STRESS AND COPING PATTERNS
* HEREDITARY/GENETIC FACTORS

THE DHHS BLACK AND MINORITY HEALTH TASK FORCE POINTED OUT THAT "THE FACTORS RESPONSIBLE FOR THE HEALTH DISPARITY ARE COMPLEX AND DEFY SIMPLISTIC SOLUTIONS. HEALTH STATUS IS INFLUENCED BY THE INTERACTION OF PHYSIOLOGICAL, CULTURAL, PSYCHOLOGICAL AND SOCIETAL FACTORS THAT ARE POORLY UNDERSTOOD FOR THE GENERAL POPULATION AND EVEN LESS SO FOR MINORITIES."

position (SEP) to minority health, a working paper of the DHHS Secretarial Task Force concluded the following:

- Minority status and SEP are closely associated, and the evidence suggests that a portion of the difference in health between whites and minorities can be explained by differences in SEP.

- In analyses of all causes of mortality, survival differences in cancer of the breast and prostate, male lung cancer incidence, and mortality from coronary heart disease, minority/white differentials in health decrease significantly when SEP is taken into account.

- The association of low SEP with minority group membership has consequences for health.

- There are significant differences between the various minority groups with respect to both SEP and to health. However, our understanding of the role of SEP in minority health is compromised by the lack of data on patterns of incidence, survival and medical care utilization.

However, the data displayed in Tables 4 and 5 indicate that blacks and other minorities are disproportionately found in Maryland's poor population. However, Maryland data which examines race, health status and socio-economic position is limited. Further research in this area is warranted.

Access to and Use of Health Services

There is evidence that differential access to health services exists by race in Maryland and the U.S. The observed differences in access are thought to also partially explain existing disparities in health status by race.

Access to health care is a multi-dimensional concept which describes an individual's willingness, ability and actual entry into the health care delivery system. It is influenced by characteristics of the delivery system such the level and distribution of available resources, cost, provider characteristics, and characteristics of the individual requiring or seeking care.

A framework for understanding differential use of health services has been suggested by Aday and Andersen. Within this framework, the use of health services is thought to be dependent upon predisposing, enabling and need factors. Predisposing characteristics are factors which suggest the likelihood of using services and which exist in the individual before the onset of illness. They include (1) characteristics which cannot be changed such as race or ethnicity, age, sex, and (2) those which are amenable to change such as educational level, knowledge of good health practices, knowledge of the availability of health care services and how to access them, and general health care attitudes and beliefs. Enabling factors describe the individual's ability to secure services as indicated by the (1) individual's personal resources such as family income, health insurance coverage, and employment status, and (2) the availability of community health resources, including types of providers and their characteristics. Finally, need factors attempt to measure health status and the reasons for seeking care.

Need for care is the greatest predictor of use of health services. However, need for services does not fully explain the variance in the use of health services. Access to or use of health services, is thought to equitable to that extent that need factors explain

TABLE 4

SELECTED ECONOMIC CHARACTERISTICS OF
MARYLAND'S RACIAL MINORITIES

	% Poor, 1979	Avg. Family Income, 1979
Total	9.8%	$26,532
Black	21.3%	$19,579
Native American/Alaskan Native	20.7%	$20,700
Asian and Pacific Islander	8.8%	$30,094
Hispanic Origin	12.7%	$26,381
White	6.3%	$28,337

Source: U.S. Census Bureau, 1980

* BLACKS AND AMERICAN INDIANS ARE THREE TIMES AS LIKELY AS WHITES TO BE POOR.

* IN 1979, ASIAN/PACIFIC ISLANDERS HAD THE HIGHEST ANNUAL FAMILY INCOMES, FOLLOWED BY WHITES AND HISPANICS. BLACKS AND AMERICAN INDIANS HAD THE LOWEST AVERAGE FAMILY INCOMES.

TABLE 5

BLACKS AS A PERCENTAGE OF MARYLAND'S POVERTY POPULATION

	Total Population	Black Population	
		Number	Percent
Demographic			
Total Population, 1980	4,216,975	957,418	22.7
Children under 16	1,085,658	301,167	27.7
Elderly (65+)	395,609	57,056	14.4
Family Status			
Children under 18 in Female Headed Households	224,170	132,219	60.0
Low Income			
Poor Persons	404,560	198,493	49.1
Poor Elderly	47,375	16,063	33.9
Poor Children under 16	128,458	74,043	57.6
Poor Children under 18 in Female Headed Households	90,208	63,849	70.8

Source: U.S. Census Bureau

* BLACKS ARE DISPROPORTIONATELY FOUND IN MARYLAND'S LOW INCOME POPULATION.

utilization. Conversely, access is inequitable when use is explained by social variables such as race, insurance coverage or other enabling factors. Inequities in the use of health services exist, as evidenced by the finding that there are utilization differentials by race.

Race and Use of Health Services

In 1980, the U.S. Office of Civil Rights asked the Institute of Medicine to appoint a Committee to investigate disparities in health services use by race. Through a review of relevant research, civil rights enforcement activities, anecdotal data and findings from a series of hearings and briefings, the Institute attempted to document the extent to which race and ethnicity are associated with the ability to obtain health care and the amount and quality of care received.

The Committee concluded the following:

- Race is associated with differences in the use of health services and that these differences do not mirror differences in need. Unfortunately, the causal relationship between these associations are complex and poorly documented.

- A variety of forms of racial separation or segregation exist in the U.S. health care system.

  - Racially identifiable hospitals continue to exist in many large cities.

  - Blacks are more likely than whites to see general practitioners rather than specialists.

  - Blacks are less likely than whites to see private physicians regardless of income level or type of health insurance coverage.

- Black Medicaid recipients are subject to double jeopardy, i.e., in addition to whatever discrimination exists against Medicaid recipients, there is also discrimination against blacks within the Medicaid population.

- There is a strong likelihood that racial discrimination is an important factor in the admission of blacks into nursing homes, though how widespread a factor is not clear.

- Racial/ethnic patterns in health care deserve much more serious and systematic attention than they have received from researchers and government statistical agencies.

In Maryland, data from selected studies and the Medicaid Program indicate that blacks have less access to health care services as measured by health insurance status, types of providers utilized and the availability of providers in minority communities. This information is summarized below.

Health Insurance Coverage

As Tables 6a and 6b show, minorities in Maryland are twice as likely as whites to be uninsured. Studies indicate that lack of health insurance coverage and low income serve as major barriers to the use of medical services.

HEALTH INSURANCE COVERAGE BY RACE IN MARYLAND

Table 6a

Health Insurance Coverage of Adults, 18+
by Race and Income, Maryland, 1982

Income	% Lacking Coverage for Hospital Care	
	Black	White
All Incomes	12%	6%
<$15,000	20%	16%
$15- 9,000	3%	4%
$29,000+	4%	2%

Source: 1982 Maryland Household Survey

Table 6b

Health Insurance Coverage by Race, Baltimore City, 1980

Insurance Type	Black	White
Private	40%	67%
Medicaid	39%	10%
Medicare	5%	15%
None	16%	8%

Source: Central Maryland Health Interview Survey, Johns Hopkins University, 1980.

Blacks and other minorities are four times more likely than whites to be Medicaid recipients. Maryland data have consistently indicated that there are racial differentials in payment and utilization levels within the Medicaid Program. On average, Medicaid payments are higher on behalf of whites than minorities. White Medicaid enrollees are nearly 2 1/2 times more likely to receive nursing home care as compared to black elderly enrollees of the same age. In Baltimore City in 1982, Medicaid payment for White AFDC enrolled children were significantly higher than for black AFDC enrolled children.

Inadequate Prenatal Care

Minority expectant mothers in Maryland are three times as likely as white mothers to receive late or new prenatal care. Lack of prenatal care is linked to higher rates of low birth weight and accompanying handicapping conditions.

Sources of Care Utilized

Whites are less likely than blacks to report having no regular source of medical care. Minorities are more likely than whites to receive care in public clinics and emergency rooms where care is less comprehensive, continuous and preventive in nature. Conversely, whites are significantly more likely to use private physicians.

Health Knowledge and Cultural Attitudes and Beliefs

Adequate information concerning how knowledge about good health practices and/or the availability of services by minorities for specific types of services (e.g., prenatal care, primary care, prenatal health services), and in specific geographic areas (i.e., urban or rural) in Maryland is unavailable. Further research in this area is also warranted.

Lifestyle/Health Risk Factors

Cigarette smoking is the chief preventable cause of death in the United States. It is associated with 30% of all cancer deaths, 90% of all lung cancer deaths, coronary heart disease, low birth weight, bronchitis and emphysema, cancers of the larynx, oral cavity, esophagus, bladder pancreas and kidney. As Table 7 shows, the prevalence of cigarette smoking is greater among blacks than whites.

Alcohol abuse is a major risk factor for cirrhosis, cancer and unintentional injuries. There is evidence that alcohol abuse has a major impact on the health of blacks and american indians. Cirrhosis death rates are disproportionately higher for these two groups. Black american men aged 35 to 44 are ten times as likely as white men to acquire cancer of the esophagus, a leading cause of which is alcohol consumption. The diagnosis of alcoholism accounts for an estimated 3.2% of all Native American deaths nationwide, which is approximately four times the national average.

Access to Surgical Procedures

Large black/white differentials in access to surgical procedures also exist in Maryland. For many elective surgical procedures, white rates are higher than black rates. These include cataract surgery, gall bladder removal, hernia repair, back and knee surgery and coronary artery bypass, which is 3 times higher for whites. The causes of these differentials are unclear, but may include differences in disease prevalence, physician practice styles, access to providers, patient preferences, income or health insurance differences or racial discrimination. The DHMH's Division of Medical Practice Patterns expects to complete an analysis of this area early next year.

TABLE 7

SELECTED RISK FACTORS BY RACE AND SEX,
MARYLAND ADULTS, 1982

Risk Factors	Total Adults	WHITE		BLACK	
		Male	Female	Male	Female
Smoking					
Percent who currently smoke	34.3%	33.2	31.3	47.3	39.3
Average number of cigarettes per day	20.2	24.0	20.2	15.4	14.2
Percent who have tried to quit smoking	69.0%	70.8	69.4	66.8	64.7
Alcohol Consumption					
Percent who drink 5 or more drinks in one sitting 1-2 times or more per week	10.4%	15.5	3.4	18.5	5.2
Percent who drink 5 or more drinks in one sitting 3 or more times per week	3.0%	5.5	0.6	6.0	2.0
Hypertension					
Average diastolic blood pressure greater than or equal to 90 mmttg. or on medication to control hypertension	21.4	22.7	17.7	24.9	28.0
Exercise					
Percent who do not engage in regular exercise	38.3%	38.4	40.9	29.4	34.5

Source: Maryland Statewide Household Survey

APPENDIX B

Task Force Members and Staff

TASK FORCE MEMBERS

Task Force on Minority Health Manpower Development

Loretta Richardson, Ph.D., Chairperson
Carl Sardegna, Vice Chairperson

Geneva Bowser
Bernellyn Carey
Fabian Desbardes, D.D.S.
Patricia Ghiglino-Lopez
Francis Green
Miles Harrison, M.D.
Warren C. Hayman, Ed.D.
Louis Murdock, Ph.D.
Phillip Neary
Morton Rapoport, M.D.
Doresa Taylor
Levi Watkins, M.D.
Carol Weems

Task Force on Maternal, Child and Family Health

Maria Pou, Chairman

Gwendolyn Barbour
Lillian Blackman, M.D.
Lenora Davis
Robert Drachman, M.D.
Elizabeth Gong
Polly Harrison, M.D.
Patricia King
Juanito Lopez, M.D.
Ruth Massinga
Paula McLellan
Nathania Miles
David Nagey, M.D., Ph.D.
Donna Petersen
Raymond Terry, Sr., Ph.D.
Emmaline Woodson

Task Force on Finance, Access and Indigent Care

Rudolph Arredondo, Chairperson
Robert Heyssel, M.D., Vice-Chairperson

Elizabeth J. Blocker
Susan Feigenbaum
Monica Ferraro
R. Dena Green
Annabelle Gregory
Jackqueline Hargrove
Barbara Knox
William Jews
Paula B. McLellan
Katheryn Miller
Douglas Morgan
Frank Monius
Amy Spanier

Task Force on Substance Abuse

Helen McAllister, M.D., Chairperson
Decatur Trotter, Vice-Chairperson

John Bland
Maxie Collier, M.D.
Eugenia Connelly
Michael Fuller
Grady Dale, Ed.D.
Nancy Lowe Connor, D.P.A.
Frank Jordan
Robert McDaniel, M.D.
Gaynor Oxendine
Charles T. Rosendale
Nollie P. Wood, Jr., Ph.D.

Task Force on Homicide, Suicide and Unintentional Injuries

Kurt Schmoke, Chairperson
Bishop Robinson, Vice-Chairperson

Alda Anderson
Susan Baker
Timothy Baker, M.D.
Gustavo Caballero
Phillis A. Diggs
Leroy Durham, Ed.D.
Joyce Fair
Lois Fenner Giles
Ronald E. Hollie
Colin Loftin, Ph.D.
Daisy Morris Murphy
Mable Palmer
Moses B. Pounds, Ph.D.
Egya Quaison-Sackey, M.D.
Adele Wilzack

Task Force on Cardiovascular Disease, Cancer and Other Leading Causes of Minority Morbidity and Mortality

Paula Hollinger Chairperson
Jose Yosuico, Vice-Chairperson

Edna Amador
Lee R. Bone
Kay Edwards, Ph.D.
Donald O. Fedder, Ph.D.
Jean Gaffney
Harry Johnson
I. Michael Miles, M.D.
James Moore, D.D.S.
Aschaw Osei-Wusu, M.D.
Pearl Price
Elizabeth Ramsey
Elijah Saunders, M.D.
Michaeline Sliverstein
Betsy Simon
John Southard, M.D.
Carmine Valente, Ph.D.

Task Force on Aging and Mental Health

Aris Allen, M.D., Chairperson
Sonya Gershowitz, Vice-Chairman

Mack Bonner, M.D.
Edward Brandt, M.D.
Wendy Garson
Judith Hannes
Patricia Harris
Peter P. Lamy, Ph.D.
John Maupin, D.D.S.
Gayle McCleary
Edgar Rivas
Paul Ruskin, M.D.
Jean Snyder
Martha Sotomayer, Ph.D.
George Taler, M.D.
Ulder Jane Tillman, M.P.
Darline Wakefield
Ellie Wang
Sallie L. Welles
Shirley Whitfield

COMMISSION AND TASK FORCE STAFF

Commission Staff

Karl Aro, Staff Coordinator
Yvette McEachern
Lynne Taylor

Task Force on Maternal, Child and Family Health Issues

Yvette McEachern
Frances May

Task Force on Finance, Access and Indigent Care

Karl Aro
Theresa Johnson

Task Force on Substance Abuse

William Somerville
Kojo Odai

Task Force on Aging and Mental Health

David Ianucci
LaVern Ware

Task Force on Cardiovascular Disease, Cancer and Other Leading Causes of Minority Morbidity and Mortality

Barbara McLean
Jeanette Washington

Task Force on Minority Health Manpower Development

Yvette McEachern

Task Force on Homicide, Suicide and Unintentional Injuries

Lynne Taylor
Marisa Mirjafary